STATE OF MAINE
GOVERNOR'S OFFICE OF HEALTH POLICY AND FINANCE
15 STATE HOUSE STATION
AUGUSTA, MAINE 04333-0078

JOHN ELIAS BALDACCI
GOVERNOR

TRISH RILEY
DIRECTOR

ELLEN SCHNEITER
DEPUTY DIRECTOR

NOTICE

To: **Interested Parties**
From: **Ellen Jane Schneiter, Deputy Director**
RE: **Proposed Value of Capital Investment Fund (CIF)**
Date: **December 9, 2005**

On October 28, 2005, the Governor's Office of Health Policy and Finance published a Notice of Proposed Value of the Capital Investment Fund, in accordance with Chapter 101, Capital Investment Fund. The Notice, which was published in the *Kennebec Journal* –as well as a detailed discussion of the process used to determine the proposed value sent to persons on the relevant Interested Parties list – solicited public comment on the proposed value of the Capital Investment Fund (CIF) either at a public hearing scheduled for November 16, 2005, or in writing, with written comments to be submitted no later than close of business on November 28, 2005. Six parties provided comments for consideration. A list of those parties – along with a summary of their comments and our responses to them – are provided as an attachment to this memo.

After considering the comments, GOHPF issues the following final CIF amounts:

	Small projects	Large Projects	Total
Non-Hospital	$115,474	$1,039,267	**$1,154,741**
Hospital	$808,319	$7,274,869	**$8,083,188**
Total			**$9,237,929**

Response to Comments
Governor's Office of Health Policy and Finance
Valuation of the Second Capital Investment Fund

On October 28, 2005, the Governor's Office of Health Policy and Finance published a Notice of Proposed Value of the Capital Investment Fund, in accordance with Chapter 101, Capital Investment Fund. The Notice, which was published in the *Kennebec Journal* –as well as a detailed discussion of the process used to determine the proposed value sent to persons on the relevant Interested Parties list – solicited public comment on the proposed value of the Capital Investment Fund (CIF) either at a public hearing scheduled for November 16, 2005, or in writing, with written comments to be submitted no later than close of business on November 28, 2005. Six parties provided comments for consideration. A list of those parties – along with a summary of their comments and our responses to them – are below.

1. David Winslow, Maine Hospital Association
2. Dave Shannon, Penobscot Valley Hospitals
3. Paul Gray, MaineHealth
4. Chuck Gill, Central Maine Healthcare
5. Jean Mellet and Dick Fournier, Eastern Maine Healthcare
6. Joe Ditre and Hilary Schneider, Consumers for Affordable Healthcare

Comment: A number of commenters focused on aspects of the methodology articulated in the Capital Investment Fund (CIF) rule, such as:

(a) how to spread the costs of extraordinary projects when debiting the costs of such projects against multiple years' CIFs [Commenters 3, 5];
(b) the reasonableness of adjustments under the rule and the effect those adjustments have on the CIF amount [Commenters 1, 2, 3, 4];
(c) the effect of not carrying over unspent amounts from one CIF to the next on the amounts available for new projects under the most current year's CIF [Commenters 1, 3, 5]; and
(d) whether adjustments for inflation are sufficient given that third years operating costs do not occur until several years after application [Commenter 3].

In contrast, Commenter 6 noted that the formula used to size the Capital Investment Fund was promulgated through rulemaking, with ample opportunity for public comment, both after issuance of the draft rule and again when the legislature reviewed the final rule. The formula in the rule was adopted by the Legislature as part of the major, substantive rulemaking process under the Maine Administrative Procedures Act.

Response: We appreciate that commenters have concerns regarding the CIF formula. However, we agree with the conclusion presented by Commenter 6. As was specified in the Notice of Hearing, the process we are currently engaged in focuses strictly on the calculation of the CIF amount and advances in technology that should be considered when sizing the Fund, as opposed to the rule's methodology to the arrive at the amount Comments regarding the methodology that forms the basis for calculating the Fund value were timely raised during the rulemaking proceeding. While the rule does reserve room for discretion with regard to certain aspects of the Fund value, the mathematical approach to calculating the basis for that value are clearly set out in the rule; it is that mathematical approach which Commenters 1-5 address in these comments.

We decline to alter the proposed value of the Fund in response to those comments offered that relate to the methodology of the Rule. However, we have chosen to provide some discussion related to questions raised regarding the interaction of the CIF rule and the CON review process, including the issue of the inflation adjustment, raised both outside of this comment process and in discussions surrounding the valuation of the Capital Investment Fund. Please see the general discussion on this topic at the end of this document.

Comment: The effective year of the second CIF is 2006, but the preliminary value of the Fund was calculated as if the effective year of the second CIF is 2005. [Commenters 1, 2, 3, 5]

Response: We agree with the commenters and have revised the CIF value accordingly. The effect of this revision is to: (a) adjust the years going into the historical average for one more year of inflation; and (b) change the five year historical average upon which the calculation is based so that it includes CON approvals in 2005 and does not include CON approvals in 2000, so that the five year historical average after adjustments for inflation and spreading the costs of extraordinary projects is $10,807,716.

This results in the new CIF values shown below:

	Small projects	**Large Projects**	**Total**
Non-Hospital	$115,474	$1,039,267	**$1,154,741**
Hospital	$808,319	$7,274,869	**$8,083,188**
Total			**$9,237,929**

Comment: The inclusion of data from 2004 in the 5 year historical average artificially reduces the CIF, since there was a CON moratorium that year. [Commenters 1, 2, 5]

Response: The revision made in response to the previous comments regarding the years used to form the historical basis of the Fund value addresses this concern. The CON moratorium was on the acceptance of new letters of intent (LOIs) from May 2003 to May 2004. A likely effect of the moratorium was that LOIs that otherwise (i.e., absent the moratorium) might have (a) been submitted during that time period and (b) been approved in 2004, did not come in until after May 2004, increasing the likelihood that they would be approved in 2005 as opposed to in 2004. Since we are now including approvals in 2005 in the five year historical average, projects delayed by the moratorium are included in the historical average upon which the CIF is based.

Comment: Hospitals have assumed that debiting the partial costs of extraordinary projects approved under the first CIF against the second CIF will result in a reduction in the amount of the second CIF that is available for new projects. However, GOHPF has never clearly articulated whether this is indeed the case. [Commenter 3]

Response: We clearly articulate that, based on the revised CIF amount ($10,807,716), there will be $4,285,723 available for new hospital projects ($8,083,188 minus the $3,797,466 used by extraordinary projects from the previous CIF).

Comment: DHHS and GOHPF have issued differing guidance on the treatment of how cost of extraordinary projects (those with third year costs over $2 million) are spread over multiple years. [Commenters 3,5]

Response: We agree that DHHS and GOHPF should not issue differing guidance. The rule clearly states that:

1. For purposes of calculating the historical average, "In the case of extraordinary projects, a maximum of $2,000,000 in third year capital and operating costs shall be recognized in the year in which project approval was granted, with the balance of those costs allocated over subsequent years. In no case shall the allocated balance of such costs exceed $2,000,000 in any one year."

2. For purposes of debiting against the CIF, "A maximum of $2,000,000 shall be debited against the Capital Investment Fund level for any individual project in a single year. In the case of an extraordinary project, where the project's total costs exceed this maximum, the total cost of the project shall be allocated in equal amounts over multiple years, with no one allocation exceeding $2,000,000."

GOHPF and DHHS officials have spoken and agree that all guidance will follow these provisions.

Comment: One commenter raised the question of whether the costs of an extraordinary project would need to be debited against multiple years even if there is "room" within the CIF under which it is approved. [Commenter 5]

Response: The rule does not make a distinction as to whether the costs of an extraordinary project would need to be debited against multiple years under different circumstances. We read the rule as instructing that the costs are debited against multiple years in *all* circumstances. However, we note that if it does ever come to pass that the costs of an extraordinary project are debited against multiple years in spite of the fact that there is "room" within the CIF under which it is approved, the rule allows consideration of the resultant unspent balance when sizing the subsequent CIF.

Comment: One commenter raised the following hypothetical: if DHHS has reviewed three projects, and there is $500,000 in credits remaining in the CIF, would DHHS "skip" a fourth project if its costs exceeded $500,000 and go to a fifth if its costs are less than $500,000.

Response: This question is appropriately directed to DHHS, which administers the Certificate of Need program and debits against the CIF resulting from approval of CON applications. GOHPF does not play any role in the review or approval of any such application. We did refer the comment offered to the CON staff of the Department of Health and Human Services and they have provided the following clarification on the issue. DHHS begins review of all applications concurrently, and to the extent possible, issues recommended decisions to the Commissioner on the merits of each application under the CON law and rules and the state health plan priorities, subject to the limits of the CIF. This batching of applications and decision making process facilitates an objective review of each application, without regard to the amount of credits in the CIF.

Comment: The CIF rule allows the base value of the Fund to be adjusted for certain other considerations, one of which is unused balance remaining in the CIF from a prior year. Several commenters argued for an upward adjustment to the second CIF value to recognize that there were unused monies remaining in the first CIF, on the grounds that doing so would compensate for the fact that a significant portion of the second CIF will be used by the carryover debits of extraordinary projects approved under the first CIF. In contrast, another commenter expressed support for the CIF value as proposed, which specifically considered and declined to include an adjustment for unspent balances. [Commenters 1, 3, 5, 6].

Response: As we noted in our October 28, 2005 notice to interested parties, we considered rolling the unused balance of $1,171,933 remaining in the hospital portion of the prior CIF ($575,940 for small projects and $595,993 for large projects) forward into the new CIF value and decided not to make any adjustment for the unspent balance, based on the considerations below:

- The third year operating costs of hospital approvals under the prior CIF totaled $8,384,933, which exceeded the hospital portion of the prior CIF by $2,625,533. It is possible for total approvals to exceed the CIF value – and for there to still be an unused balance – because of the Chapter 101, section 5, which instructs that the costs of large projects will be spread equally over multiple years for purposes of debiting against the CIF.

- The unspent balance is not associated with disapproving any hospital applications under the first CIF, so no adjustment needs to be made.

We stand by our decision to not make such an adjustment. As noted by Commenter 6, who supports the decision to not make such an adjustment, the purpose of the CIF is cost containment. If the full amount available for new hospital projects ($4,285,723) is used under the CIF – and we note that it is possible that approvals could exceed that amount (as they did in 2005), due the "equal spread" provision – the total new hospital costs added to the system over the two year period 2005-2006 would be $12,670,656, an average of $6,335,327 per year. We believe such a value strikes the appropriate balance of containing costs while allowing adequate hospital capital improvements.

Comment: Two commenters noted that the division of the Fund into large project and small project components inappropriately splits health care into "silos" and artificially reduces credits in the fund. [Commenters 1, 5]

Response: We begin by noting that 2 MRSA c.5, section 102(2) requires that the process for determining the CIF "must include the division of the total capital investment fund amount into non-hospital and hospital components, must establish large and small capital investment fund amounts within each component." The statute does not grant GOHPF discretion regarding the existence of small and large components.

Next, we note that Chapter 101, section (3)(c) of our rules establishes the amount set aside for small projects at 10% of each component (10% of the hospital component and 10% of the non-hospital component) of the Fund. As discussed earlier, the current review process focuses on the CIF amount, *not* on the process set forth in the rule to arrive at the base amount.

Where the statute and rule *do* allow discretion is regarding the transfer of unused amounts between the large and small components during a given year; e.g., if there are

no small projects in a batch of application under a given CIF, can large projects use the Fund value allocated to small projects.

After careful consideration and consultation with DHHS, we have concluded that it is appropriate to permit some transfer of unused amounts between the large and small components during a given year. The legislature's intent in establishing large and small amounts within each component was to ensure that small projects are not crowded out by large projects, and ***not*** to reduce the amount available for total hospital and non-hospital investment, which, as the commenters point out, is the effective result of prohibiting the transfer of unused amounts between the large and small components during a given year.

The timing of review cycles under DHHS's CON rules will have an impact on when unused amounts become known and can be transferred. The following matrix summarizes relevant dates in the CON application and review process:

	LOI due on or before	**Review Cycle Begins on or before**
Large	October 1	January
Small	January 1	April

If there are no small project LOIs submitted by the January 1 deadline, it is clear that the full value of the small project component will be unused and is therefore available for use by large projects.

If, on the other hand, there are small project LOIs, the ultimate amount of unused small project component funds will not be known until a final decision is made on all small project applications. Any unused small project CIF balance would then be available to fund any large project applications deemed meritorious for approval but that were not funded due to the lack of CIF credits for large projects.

Having concluded that a transfer of unused funds between small and large components is permissible in the future, we note that permitting such a transfer under the first CIF would have had no effect on availability of funds in the first review cycle, because the total amount debited ($4,587,468) under the first CIF did not exceed the hospital large project component of the first CIF ($5,183,460). Further, no projects were turned down under the first CIF.

Finally, we anticipate that some interested parties might argue that permitting the transfer of unused funds between small and large components sets a precedent to allow a transfer between unused hospital and non-hospital components. We therefore take this opportunity to clearly state that such a transfer will *not* be allowed. As we pointed out in our July 9, 2003 response to comments during the original rulemaking process, the starting point for determining the CIF is the most recent five-year historical average of hospital CON approvals. This five year average then undergoes a series of adjustments to come up with an appropriate hospital portion of the CIF. The total CIF is then determined by grossing that number up so that non-hospitals receive 12.5% of the total fund. Allowing hospitals to use any unused non-hospitals fund amount would run contrary to the clearly stated policy that the hospital portion of the CIF is the appropriate limit for hospital capital investment.

Comment: One commenter noted there are no technological developments that would require a discretionary adjustment to the Fund value [Commenter 6].

Response: We noted in our October 28, 2005 Notice to interested parties that the Maine Quality Forum has indicated that there are no technological developments that would require an adjustment to the Fund. No other commenters raised any issues pertaining adjustments based on technological developments.

Discussion of Inflationary Adjustments: As noted above, the issue of inflation adjustment, raised both outside of this comment process and in discussions surrounding the valuation of the CIF, merits specific discussion in this Response to Comments, although it does not impact the actual value of the CIF.

Specifically, we point out the following regarding adjustments for inflation in: (1) CON review thresholds, (2) the CIF itself, and (3) estimates of third year operating costs:

Prior to the passage of the Dirigo Health Reform Act, CON review thresholds were not adjusted for inflation. Enactment of the Dirigo reforms amended CON law so that the thresholds increase by the medical CPI each year.

The Dirigo Health Reform Act also created the Capital Investment Fund. Section 3(A)(1) of the CIF rule (Chapter 101, Capital Investment Fund) results in the CIF being adjusted each year for inflation.

At least one hospital has expressed the concern that the state is only adjusting the thresholds and the CIF for one year of inflation, but third years costs are several years out and should therefore be adjusted for several years of inflation. We disagree with this position based on the following reasoning:

- Each year, both the review thresholds and the CIF are adjusted for inflation.

- Likewise, when CON applicants make their estimate of third year costs, the 3rd year costs of any project will be the rate of inflation higher than the 3rd year costs of the same project if the project had been submitted a year earlier.

- Thus, the thresholds, the CIF, and inflationary changes in projects' estimated third year costs all occur at the same time; i.e., they all move together with inflation each year, so that inflation: (a) has no adverse impact on what does versus does not fall under the thresholds in a given year, and (b) does not reduce how much is available under the CIF.

- This also addresses concerns about larger projects being "disproportionably adversely affected over smaller projects that take less time to complete;" i.e., there is no disproportionate adverse affect on large projects, because, as noted in our second point, the 3rd year costs for any project (large or small) are the rate of inflation higher than the 3rd year costs of the same project if it was submitted a year earlier. Thus, large and small projects receive equal treatment.